DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 Worth Road
Fort Sam Houston, Texas 78234-6000

MEDCOM Regulation
No. 500-5-2

1 November 1999

Emergency Employment of Army and Other Resources

U.S. ARMY MEDICAL COMMAND MOBILIZATION CONCEPT OF OPERATIONS

Supplementation of this regulation and establishment of forms other than MEDCOM forms are prohibited without prior approval from Headquarters, U.S. Army Medical Command, ATTN: MCOP-P.

*This regulation supersedes Concept of Operations, Volume II, Part 1, HSC-MPS, Undated.

Chapter 1
Introduction and Overview

1-1. History.
This is the first printing of this publication. It incorporates the information in the Concept of Operations, Volume II, Part 1, HSC-MPS, Undated, that is rescinded.

1-2. Purpose.
This publication describes the U.S. Army Medical Command's (MEDCOM) Mobilization and Contingency Planning System concept of operations. It includes the general policies, procedures, and methods of operation required to support the Army plan during mobilization and deployment of Army forces.

1-3. General.
The Army Surgeon General (TSG) is accountable for the Army health care system and health care policy. The MEDCOM is the Major Army Command (MACOM) responsible for health care delivery to Army forces.

1-4. Responsibilities.
The MEDCOM responsibilities include:

a. Prepare integrated mobilization plans and procedures to incorporate missions specified in the Army Mobilization and Operations Planning and Execution System (AMOPES).

b. Function as the Army's principal planning agent for medical coordination and support of the Commander in Chief U.S. Atlantic Command (CINCUSACOM) Integrated Continental United States Medical Operations Plan (ICMOP).

c. Develop plans, as directed by the U.S. Army Forces Command (FORSCOM) Mobilization and Deployment Planning System (FORMDEPS), to expand medical support and training to meet the time-phased flow of units as provided by the Global Command and Control System-Army (GCCS-A) Mobilization Planning Application. Develop plans to accept the projected flow of patients returning from the theater(s) of operations.

1-5. Mission.
The MEDCOM provides health care support for mobilization, deployment, sustainment, and demobilization of Army forces. It will simultaneously maintain the capability to provide continuity of patient care while ensuring it retains the capability to care for patients returning from the theater(s) of operations, and for authorized beneficiaries. The MEDCOM also provides individual Army Medical Department (AMEDD) training and medical materiel, research, and development to support the Army mobilization force. The MEDCOM mission is further delineated as follows:

a. Deploy individuals and teams under the provisions of the Professional Filler System (PROFIS) and Caretaker Professional Filler System (CT-PROFIS).

b. Provide direct health care support to the mobilizing, deploying, and sustaining base military forces.

c. Continue to provide health care to eligible beneficiaries within the limitations of available resources.

d. Expand the Army's direct military health care system to provide treatment for patients evacuated from the theater(s) of operations.

e. Provide individual skill training for the essential medical skills needed during mobilization and/or contingency operations.

f. Provide medical support to protect and sustain the health and performance of the Army force across the continuum of military operations.

g. Provide for health promotion, preventive medicine, and health care services.

h. Provide dental services.

i. Provide veterinary services.

j. Provide blood and blood products in support of contingency requirements.

1-6. Overview.
The transition from community based health care to mobilization or contingency operations is a seamless process with changes occurring on an exception basis in response to requirements. Policies and procedures set forth in this and other mobilization planning system documents will mirror those established during peacetime operations. The MEDCOM's response to a contingency operation or mobilization will involve the deployment of personnel; receipt of Reserve Component (RC) units and individuals; and increased workload, to include bed, blood collection, and veterinary support expansion proportionate to the crisis response. External systems such as patient regulating may require procedural changes, however, internal systems should not be affected. Command and control and lines of communication remained fixed with the most notable difference being an increase in reporting frequency.

a. The ICMOP, as directed by the Joint Staff and developed by the CINCUSACOM, will be the focal point for integrating joint continental United States (CONUS) medical mobilization planning.

b. Selected U.S. Army Medical Centers (MEDCEN) will be designated as primary receiving centers (PRC). A PRC is a hospital specified to receive patients returning to CONUS from the theater(s) of operations. The levels of care in the PRC are primarily for intensive and intermediate care patients with a few minimal care beds. Although all PRCs will have the capability to provide the full range of patient care, selected PRCs may be directed to place an emphasis on selected clinical specialties and will receive the initial influx of patients regulated for those specialties.

c. The CONUS return to duty policy provides the guideline for determining which patients receive treatment in a military medical treatment facility (MTF) and which ones should be transferred to a Department of Veterans Affairs (DVA) or National Disaster Medical System (NDMS) associated civilian medical facility.

(1) To support these policies, Public Law 97-174 designates the DVA hospital system as the primary backup support system to the military health care system. The NDMS, as described in Department of Defense (DOD) Directive 6010.17, functions as the national safety net for meeting the remaining hospitalization requirements during contingencies or national emergencies.

(2) For planning purposes, the CONUS return to duty policy is 60 days. Under this policy, patients expected to return to duty within 60 days will be hospitalized in the direct military care system. Patients requiring medical care exceeding 60 days, and those for whom specialty treatment is not available in the military health care system, will be transferred to a DVA or NDMS associated civilian hospital.

d. The MEDCENs are regional tertiary care centers. Selected MEDCENs may be directed to develop and maintain the capability to provide specialized health care to certain patient types, whether those patients are in their facility, at another facility in CONUS, or overseas.

e. The provision of health care in the CONUS sustaining base requires a well coordinated and integrated planning effort among the Services, the DVA, Federal agencies, and NDMS associated civilian health care institutions. An integrated regional planning process is necessary to achieve an orderly transition to a contingency medical support structure. For MEDCOM to accomplish its mission, major subordinate commands' (MSC) mobilization plans must integrate fully with other military, Federal, and NDMS

associated civilian health care facilities and resources within their area of responsibility (AOR).

Chapter 2
Structure and Coordination

2-1. Command relationships.
Normal command relationships will continue during mobilization to ensure a rapid and seamless transition to integrated operations.

a. The MSCs are the MEDCOM's medical planning agencies in support of joint medical mobilization planning initiatives within their AOR.

b. The MSCs' responsibility includes the regional coordination, integration, and validation of subordinate activities' mobilization missions and plans. The goal of this regional planning effort is to coordinate procedures for the use of military medical resources, and to facilitate coordination for use of the DVA hospital system and the NDMS during national emergencies.

c. The MSC Commanders are responsible for managing the Army health care delivery system in their geographic region. The MSC Commanders will cross level resources within their AOR to achieve maximum use of capabilities. The MSCs will forward requirements in excess of their available resources to Headquarters (HQ), MEDCOM.

d. The MSCs are the conduit for the flow of information between subordinate activities and HQ, MEDCOM. The MSCs direct taskings to their subordinate activities and consolidate reports for submission to HQ, MEDCOM. Contingency communications between HQ, MEDCOM and the MSC will be through their Emergency Operations Centers (EOC).

e. The area health care mission for each MTF will coincide with the health care demand projected for each phase of mobilization.

(1) During the initial phase of mobilization, the primary demand for health care will be continuity of care and support of the mobilizing and deploying forces. The work load during this period comes from soldier readiness processing and the increase in the incidence of disease and nonbattle injuries associated with individual and unit training.

(2) The next phase begins upon the initiation of hostilities and the evacuation of patients from the theater(s) of operations to MTFs serving as PRCs. At these MTFs, the primary workload is the treatment of patients requiring intensive and intermediate care. The remaining MTFs will continue the mission of providing continuity of care and installation medical support.

(3) The third phase occurs as the theater matures and the theater evacuation policy stabilizes. During this phase, the PRCs will continue to provide intensive and intermediate patient care. Upon completion of the patient's intensive and intermediate care in the PRC, the PRC will transfer the patient to an MTF close to their home station for further treatment.

2-2. Reserve component RC) augmentation and backfill.

a. During mobilization MEDCOM will receive RC units and individuals to support its contingency mission. The alignment of these units and their activation follows the GCCS-A Mobilization Planning Application.

b. The RC units and individuals assigned to MEDCOM during a contingency or mobilization will provide support as follows:

(1) Individual Mobilization Augmentees (IMA) and Individual Ready Reserve Augmentees (IRR Augmentee). The IMAs and IRR Augmentees will backfill personnel scheduled to deploy as part of the professional Filler System (PROFIS), FORSCOM Nurses, and will provide augmentation for special missions.

(2) The RC Table of Distribution and Allowances (TDA) Troop

Program Units (TPU). The RC TPU's organizational structure depends on their mission. The TPUs that provide backfill for caretaker hospitals and forwarded deployed hospitals and units will match, by Area of Concentration(AOC)/Military Occupational Specialty (MOS) and grade, the active component personnel requirement for the supported activity. The TPUs that support bed expansion missions at specific MTFs will organize and train their unit for that mission. Other TPUs include the Installation and Deployment Support Units (IDSU). The IDSU is designed as a multiple mission unit to augment an MTF's capability to provide installation and deployment support. It is structured with up to three distinct elements, an Installation Medical Support Unit (IMSU), Blood Donor Center (BDC), and Veterinary cell. The IDSU's organizational structure may contain one, two, or all three of these elements.

c. The MEDCOM activities will establish a planning and training association with aligned RC units, as outlined in FORSCOM Regulation 11-30, The Army WARTRACE Program, and The Memorandum of Understanding between the MEDCOM and the U.S. Army Reserve Command (USARC). Commanders will establish complementary training programs to ensure the WARTRACE aligned RC unit's integration into their mobilization mission. The commanders of MEDCOM activities will maintain a current assessment of their WARTRACE aligned RC unit's capabilities and shortfalls.

2-3. Clinical staff officers.

a. The Assistant Chief of Staff for Health Policy and Services, MEDCOM, serves as the principal staff officer for all clinical policies.

b. The network of clinical staff officers provides a method to rapidly issue clinical policies and priorities, as well as providing an established procedure for obtaining expert opinions and evaluations of patient care. The two levels of clinical staff officers, MEDCOM and Regional Medical Command (RMC), which make up the network under normal operations will continue to serve as the base for the mobilization network.

c. The designated RMC clinical staff officers will monitor the provision of health care in military medical facilities, as well as maintain an assessment of the care provided to military patients who have been transferred to other Federal and NDMS associated civilian treatment facilities within their geographic AOR.

d. The MEDCOM Army Blood Program Manager will oversee the collection of blood directed by DOD through the Armed Services Blood Program Office (ASBPO).

Chapter 3
Planning

3-1. General.
The planning goal for operations from a contingency operation through full mobilization is to make an accurate assessment of resource requirements and capabilities. The commander's projection of needs and expected results from the realignment of resources is critical to the planning process.

3-2. Resource requirements and allocations.
Resources available to the commander include personnel, facilities, supplies, equipment, and funding. Each level of command is required to conduct a staff assessment to determine the availability of resources. The assessment must consider Federal and civilian health care resources available within the geographic area of responsibility.

a. Personnel. The availability of personnel resources and an assessment of their technical skills is essential in determining the capability to support the projected workload.

(1) As the mobilization process begins, shortages of personnel will occur as a result of PROFIS and Care-taker PROFIS (CT-PROFIS) departures, and the reassignment of other essential medical personnel. Initial personnel gains will be acquired from the Reserve Components, retiree recalls, and expanding the civilian work force, volunteers, the use of contract personnel, and managed care support contracts.

(2) Following the Presidential Selected Reserve Call-up (PSRC), the Individual Mobilization Augmentees and volunteers from the Individual Ready Reserve Activation Authority (IRRAA) will provide backfill for PROFIS and FORSCOM Nurse losses to deployed and deploying forces. Individual Ready Reserve Augmentees will be available at partial mobilization.

(3) During the PSRC and subsequent levels of mobilization, MEDCOM will receive augmentation and backfill for CT-PROFIS from RC hospitals and other medical units whose contingency mission is to support the health care delivery mission.

(4) For planning purposes, the first priority for assignment of personnel with highly specialized skills will be to the Primary Receiving Centers. Follow-on assignments will coincide with the missions described in Chapter 2, paragraph 2-1d.

b. Medical equipment and supplies.

(1) HQ MEDCOM establishes the priority for allocation of medical supplies and equipment and provides this information to the U.S. Army Medical Research and Materiel Command (MRMC) for implementation. The first priority for medical equipment and supplies is to deploying medical units. The second priority is to the installations supporting mobilizing and deploying units, and the third priority is to the primary receiving centers.

(2) Contingency and prime vendor contracts for mobilization have been negotiated and implemented.

c. Facilities. The MTFs and dental treatment facilities (DTF) will use only existing medical and dental treatment facilities to provide health care. The MEDCENs and medical activities (MEDDAC) will hospitalize patients only within the core capacity of the existing MTF.

d. Funds. During mobilization, RMCs will use existing funds that MEDCOM and Headquarters Department of the Army (HQDA) have not restricted. Commander, MEDCOM will submit a request to HQDA and the Office of the Assistant Secretary of Defense for Health Affairs (OASD-HA) for supplemental funding. The MSCs will maintain allocation and reporting procedures as required by HQ MEDCOM, and those procedures necessary to meet their internal management requirements.

3-3. Contracting.
Contracting for civilian services will expand to meet operational requirements. Contracting should establish prearranged service contracts in an "off-the-shelf" status for short notice implementation. Contracts for supplies and services will, where possible, contain contingency clauses to support mobilization. Prime vendor contracts will have contingency clauses. Maximum use will be made of the Logistics Civil Augmentation Program (LOGCAP), Army Regulation 700-137.

Chapter 4
Health Care Delivery

4-1. General.
Beneficiary health care services, inpatient and outpatient, will not be restricted until it becomes apparent that care to active duty personnel is being compromised due to lack of space and staffing. Available health care services and level of care to nonmilitary beneficiaries are situational and will vary from one installation to the next. As resources become less available to

care for all beneficiaries, priority of care will shift to active duty personnel followed by prioritization of other categories as specified in Title 10 US Code and Service regulations. Primary care managers and health care finders will continually assess the need for health care services to accommodate the requirements of nonactive duty beneficiaries.

4-2. Hospitalization.

a. The hospitalization portion of the health care mission will continue to require the most resources to operate, thus dictating the need for detailed regional management procedures.

b. The tiered approach to health care delivery established in normal operations will continue. The PRC in each RMC will serve as the tertiary care center. The RMC staff manages the regional health service area as an integrated health care system.

c. The MEDCENs specified as Primary Receiving Centers will receive the initial influx of patients from the theater(s) of operations in addition to providing health care support to the installation population. Their staff will support a higher ratio of intensive and intermediate care patients with a limited proportion of minimal care patients.

d. All MTFs will plan to operate at least as many intensive and intermediate care beds during a contingency as they do in normal operations.

e. All RMCs will provide the full range of patient care required for internal medicine and the associated subspecialties, general surgery, and orthopedic surgery.

f. The final organizational and specialty alignment for each RMC will depend on the completion of a detailed analysis of the potential patient flow from outside and within CONUS. Options developed for each medical facility will include an analysis of alternative health care resources available in the RMC. Final planning guidance and the mission template will come from HQ MEDCOM, Office of the Assistant Chief of Staff for Operations.

4-3. Ambulatory care.

a. During initial phases of mobilization, ambulatory care requirements will expand as health screening for deploying forces increases.

b. The MTFs with Power Projection Platforms (PPP) and/or Power Support Platforms (PSP) within their AOR will be augmented by RC IMSUs following the declaration of a PSRC. The IMSUs primary mission is to augment the MTF to assist with soldier readiness processing (SRP). The IMSU may also augment the MTF in providing a predetermined level of outpatient ambulatory care at active, semi-active, and state operated PPPs and PSPs where military health care treatment facilities do not exist. Inpatient health care treatment requirements at these locations will come from alternative sources of care (Federal or civilian). The MTFs will develop preestablished memorandums of agreement with alternative health care facilities, and close coordination will be maintained during planning and execution.

4-4. Preventive medicine.

a. The MEDCOM Preventive Medicine and Wellness Division oversees the command-wide preventive medicine and occupational health programs. They also provide preventive medicine support during mobilization. The MSCs oversee and coordinate preventive medicine and occupational health programs in their area of responsibility.

b. The U.S. Army Center for Health Promotion and Preventive Medicine (CHPPM) will provide technical support and services to enhance requested local and regional initiatives as resources permit.

Also, CHPPM will coordinate with other Federal, State, and local public health agencies that could provide alternative resources and support.

4-5. Medical research and materiel.

a. The Medical Research and Materiel Command's (MRMC) mission will shift from basic research to support of field operations during a contingency and/or mobilization. The geographical area of conflict and Army operations in that area will determine the thrust of the research and development effort after mobilization. Program priorities will be adjusted to meet critical needs.

b. The MRMC directs and manages the Class VIII (medical) supply support, and operates as the Army Service Item Control Center (SICC) for medical materiel. These activities are managed through the U.S. Army Medical Materiel Agency (USAMMA), a MRMC subordinate command.

4-6. Dental services.

a. The dental health care delivery mission belongs to the U.S. Army Dental Command (DENCOM). Dental health policy is provided by the DENCOM with decentralized implementation by the Regional Dental Command (RDC). The RDC commander is responsible for coordinating the regional priorities of dental care and integrating the applicable plans and dental resources.

b. The dental care support plan will support the installation mobilization plan to provide soldiers with dental screening and care.

4-7. Veterinary services.

a. The U.S. Army Veterinary Command (VETCOM) performs joint and global missions through the Regional Veterinary Command (RVC) structure. During mobilization, this mission will expand significantly to support Power Projection and Power Support Platforms associated with early activation, augmentation, and rapid military deployment. The implementation of this mission will occur through a coordinated prioritization by the RVCs. The RVC Commanders will serve as the regional integrator for mobilization missions involving Federal and state agencies, civilian contractors, and the resources of other military services.

b. The veterinary mission encompass all DOD activities in areas of food safety and wholesomeness, animal medicine, and veterinary aspects of research and development.

Chapter 5
Training

5-1. General.

Training and education requirements will not change significantly during a PSRC or partial mobilization. Student input levels and current courses of instruction will remain relatively constant through partial mobilization. A temporary surge in selective courses such as the officer qualification course may be experienced. Institutional training at the U.S. Army Medical Department Center and School (AMEDDC&S) will change only on full mobilization or as directed by Commander, MEDCOM.

5-2. Procedures.

a. Short of full mobilization, the AMEDDC&S will continue to provide current courses, expand to provide refresher skill training to Individual Ready Reserve (IRR) officer and enlisted personnel. Training will continue as indicated in the Army Program of Individual Training (ARPRINT).

b. Upon full mobilization, institutional training will cover the courses of instruction approved for inclusion in the Army Training Requirements and Resources System (ATRRS) and the Mobilization Training Planning System (MTPS). Student projections appear in the Mobilization Army Program of Individual Training (MOBARPRINT).

c. Graduate Medical Education (GME) programs will continue under current policies and procedures until full mobilization. Students in GME programs will not be deployed without the approval of The Surgeon General.

Chapter 6
Patient Administration and Transportation

6-1. General.
Patient administration encompasses the areas of patient affairs, accountability, medical records, and patient regulating and evacuation. The patient administrator oversees the uniform business office, releases medical information, and effects coordination with other MTFs to report the transfer of services.

6-2. Patient accountability and affairs.
The MTFs have the responsibility for accounting for and supporting Army patients, to include patient tracking, in other than Army medical facilities in their area. An MTF with area responsibility will document the requirement for mobilization patient liaison teams as part of its mobilization Table of Distribution and Allowances (MOBTDA).

6-3 Patient evacuation.

a. Regulating.

(1) Patient regulating is a function of the Global Patient Movement Requirements Center (GPMRC). Patient regulating will be accomplished in accordance with the procedures established in the Defense Medical Regulating Information System (DMRIS). Normal regulating procedures will be used initially, however as the number of patients returning from the theater(s) of operations begins to overwhelm the system, GPMRC will initiate the contingency reporting system.

(2) The RMC is responsible for coordinating intra-RMC regulating and movement of patients. The MTFs operating as PRCs will report their medical capabilities using DMRIS. The GPMRC will regulate returning casualties to the PRC for their intensive and intermediate care. Whenever possible, RMCs will return patients to their home station as soon as their medical condition and the capability of the home station MTF permit. The GPMRC is responsible for the follow-on intra-RMC evacuation of patients, however, the RMC regional patient coordinator should plan on arranging ground evacuation within 50 miles of the PRC.

b. Transportation.

(1) The evacuation of patients from the theater(s) of operations to CONUS is the responsibility of the U.S. Transportation Command (TRANSCOM). The U.S. Air Force (USAF) will move the patient to a specified airfield within the proximity of a PRC using a hub and cluster air transportation network. The PRC identified to receive the patient will have the responsibility for patient evacuation from the arrival airfield to the MTF.

(2) The RMCs will set up regional patient transportation plans for activation during mobilization to integrate the intra-CONUS movement of patients within their respective regions.

GLOSSARY

AMEDD.....Army Medical Department

AMEDDC&S.....U.S. Army Medical Department Center and School

AMOPES.....Army Mobilization and Operations Planning and Execution System

AOC.....Area of Concentration

AOR.....Area of Responsibility

ARPRINT.....Army Program of Individual Training

ASBPO.....Armed Services Blood Program Office

ATRRS.....Army Training Requirements and Resource System

BDC.....Blood Donor Center

CHPPM.....U.S. Army Center for Health Promotion and Preventive Medicine

CINCUSACOM.....Commander in Chief, U.S. Atlantic Command

CONUS.....Continental United States

CT-PROFIS.....Care-Taker Professional Filler System

DA.....Department of the Army

DENCOM.....U.S. Army Dental Command

DMRIS.....Defense Medical Regulating Information System

DOD.....Department of Defense

DTF.....Dental Treatment Facility

DVA.....Department of Veterans Affairs

EOC.....Emergency Operations Center

FORMDEPS.....U. S. Army Forces Command Mobilization and Deployment Planning System

FORSCOM.....U.S. Army Forces Command

GCCS-A.....Global Command and Control System - Army

GME.....Graduate Medical Education

GPMRC.....Global Patient Movement Requirements Center

HQ.....Headquarters

HQDA.....Headquarters, Department of the Army

ICMOP.....Integrated Continental United States Medical Operations Plan

IDSU.....Installation and Deployment Support Unit

IMA.....Individual Mobilization Augmentee

IMSU.....Installation Medical Support Unit

IRR.....Individual Ready Reserve

IRRAA.....Individual Ready Reserve Activation Authority

JCS.....Joint Chiefs of Staff

LOGCAP.....Logistics Civil Augmentation Program

MACOM.....Major Army Command

MEDCEN.....U.S. Army Medical Center

MEDCOM.....U.S. Army Medical Command

MEDDAC.....Medical Department Activity

MOBARPRINT.....Mobilization Army Program of Individual Training

MOBTDA.....Mobilization Table of Distribution and Allowances

MOS.....Military Occupational Specialty

MRMC.....U.S. Army Medical Research and Materiel Command

MSC.....Major Subordinate Command

MTF.....Medical Treatment Facility

MSC.....Major Subordinate Command

MTPS.....Mobilization Training Planning System

NDMS.....National Disaster Medical System

OASD-HA.....Office of the Assistant Secretary Defense, Health Affairs

PPP.....Power Projection Platform

PSP.....Power Support Platform

PRC.....Primary Receiving Center

PROFIS.....Professional Filler System

PSRC.....Presidential Selected Reserve Call-up

RC.....Reserve Component

RDC.....Regional Dental Command

RMC.....Regional Medical Command

RVC.....Regional Veterinary Command

SICC.....Service Item Control Center

SRP.....Soldier Readiness Processing

TDA.....Table of Distribution and Allowances

TPU.....Troop Program Unit

TRANSCOM.....U.S. Transportation Command

TSG.....The Surgeon General

U.S.....United States

USAF.....U.S. Air Force

USAMMA.....U.S. Army Medical Materiel Agency

USARC.....U.S. Army Reserve Center

USCINCACOM.....U.S. Commander-In-Chief, Atlantic Command

VETCOM.....U.S. Army Veterinary Command

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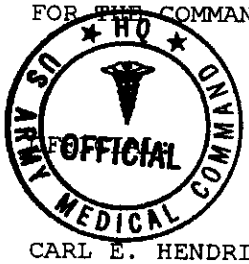

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